June 15, 1998

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-1905-FC
P.O. Box 7517
Baltimore, MD 21207-0517

Re:	Petition for Amendment of the Final Rule for the Schedule of Per-Beneficiary Limitations on Home Health Agency Costs (a.k.a., Interim Payment System Final Rule); 63 Fed. Reg. 15,718 (March 31, 1998).

Dear Ms. DeParle:

On March 31, 1998, the Health Care Financing Administration (HCFA) published a final rule with comment period concerning a new schedule of limitations on home health agency costs that may be paid under the Medicare program to home health agencies (HHAs). The rule is being promulgated by HCFA pursuant to requirements set forth in section 4602 of the Balanced Budget Act of 1997 (BBA), and is retroactive to HHA cost reporting periods beginning on or after October 1, 1997. Until a formal prospective payment system can be established by HCFA, this interim payment system (IPS) final rule provides that payment limitations must be the lower of: 1) an HHA's actual reasonable allowable costs, 2) per-visit limitations in the aggregate [as established in a prior rule, 63 Fed. Reg. 89 (January 2, 1998)], or 3) a per-beneficiary limitation in the aggregate as established by this final rule.

The Office of the Chief Counsel for Advocacy of the U.S. Small Business Administration was created in 1976 to represent the views and interests of small business in federal policy making activities.[1] The Chief Counsel is nominated by the President of the United States and confirmed by the U.S. Senate. The Chief Counsel participates in rulemakings when he deems it necessary to ensure proper representation of small business interests. In addition to these responsibilities, the Chief Counsel monitors compliance with the Regulatory Flexibility Act (RFA), and works with federal agencies to ensure that their rulemakings demonstrate an analysis of the impact that their decisions will have on small businesses.

The Office of Advocacy has a number of concerns with regard to this final rule. First, although HCFA had eight months to promulgate this regulation, no proposed rule was ever published—even though HHAs and Medicare beneficiaries would be seriously impacted. In doing this, HCFA has violated the Administrative Procedure Act (APA). Second, HCFA failed to analyze

[1] Regulatory Flexibility Act, 5 U.S.C. § 601, as amended by the Small Business Regulatory Enforcement Fairness Act, Pub. L. No. 104-121, 110 Stat. 866 (1996).

significant alternatives, failed to provide a factual basis for the singular alternative offered, and failed to assess the impact of the regulation adequately —all in violation of the RFA. Third, when Congress passed the BBA, the intent behind the legislation was to stem fraud and abuse, but HCFA has gone beyond what Congress intended and has effectively made the regulations punitive and unfair to legitimate and law abiding HHAs.

Summary of Impacts

Prior to enactment of the BBA, the government reimbursed HHAs for all reasonable costs up to certain limits. This method of reimbursement made it easier to abuse the Medicare system by charging for excessive services. The BBA, therefore, called for capped annual payments based partly on the number of beneficiaries served—regardless of the type and amount of services required by a particular patient. In addition, the BBA required that rates paid to HHAs be rolled back to fiscal year 1993-94 levels across the board. Without getting immersed in the complicated formulas used to compute payments to HHAs, it is fairly easy to discern that the BBA is creating a tremendous burden on HHAs by expecting them to serve patients in fiscal 1998-99 with less money than was provided in 1993-94. Moreover, historically high-cost providers are favored at the expense of those run more efficiently because those with higher costs in 1993-94 will be reimbursed more. A one-size fits all approach is inherently inflexible and generally causes the greatest harm to small businesses operating on a narrow margin.

In spite of the already devastating effect the BBA requirements would have on HHAs, HCFA deals the greatest blow to the continued survival of HHAs by applying unfavorable interpretations of the BBA to the IPS regulation. For instance, based on HCFA's interpretation, new providers (those without 1994 cost data) will be reimbursed at a different rate than old providers (those with 1994 cost data) because different data sets will be used to calculate reimbursement rates. New providers essentially will be reimbursed less than old providers because national median data will be used to calculate rates for new providers. Apparent in HCFA's various interpretations of the BBA throughout this rulemaking is the assumption that 1) small and new providers are all submitting fraudulent Medicare claims, and 2) small and new providers can operate with less money than older agencies providing the same services and operating in the same region.

In fact, reduced services and closed businesses can be the only results of this rulemaking. Services will likely be rationed between patients who need frequent long-term care after a hospital visit (e.g., patients of severe strokes) versus those needing only short-term recuperative care (e.g., new mothers). To date, HCFA's response to the possibility of reduced services has been less than sympathetic. On February 3, 1998, the Administrator of HCFA sent what many in the industry consider to be a threatening letter to all Medicare certified HHAs warning against prematurely terminating care for Medicare beneficiaries. The letter read in part, "HHAs are not free to reduce the amount of care ordered for patients by physicians . . . [and] are not allowed to discriminate against Medicare enrollees." The letter goes on to suggest reprisals against agencies that inform Medicare enrollees of possible reductions in service due to the payment reforms, "Any reports of HHAs misinforming beneficiaries or inappropriately terminating care

for Medicare enrollees will be considered the basis for complaint survey that could lead to termination of the HHA from Medicare."

HHAs are facing quite a quandary—they cannot afford to care for patients under the regulations for IPS and surety bonds, yet they are not permitted to reduce or deny care based on the cost and the amount of care needed. All of this comes at a time when hospitals are releasing patients earlier in the recuperation process to reduce their own costs, and expecting HHAs to care for seriously ill patients.

Aside from its obvious impacts on the HHA industry and patient care, this final rule violates the same norms of administrative procedure as the series of final rules on surety bonds and capitalization requirements for home health agencies published earlier this year.[2] In a similar petition, the Office of Advocacy submitted that the surety bond and capitalization final rule were troubling for the following reasons: 1) The final rule, although probably within HCFA's regulatory and statutory authority, goes far beyond the requirements contemplated by Congress when they enacted the BBA; 2) HCFA's good cause exception and waiver of the proposed rulemaking may be arbitrary and capricious under the Administrative Procedure Act (APA); and 3) Nearly all of the significant procedural and analytical requirements of the RFA were overlooked.[3] The instant final rule is troubling for exactly the same reasons. Moreover, as HCFA implements the laws enacted under the BBA, a disturbing pattern of disregard for the rulemaking process is emerging.

ACTION REQUESTED: Since the instant rule is now final and in effect, the Chief Counsel of the Office of Advocacy herewith petitions the agency, pursuant to 5 U.S.C. § 553(e), to 1) remove the median national limit for "new" providers, 2) change the definition of "new providers" according to existing law, 3) analyze the impact of the final rule, and 4) apply other flexible regulatory alternatives consistent with statutory intent and common sense regulatory construction. The legal arguments in support of this petition follow.

I. Waiver of Administrative Procedure

An agency is subject to the notice and comment requirements contained in 5 U.S.C. § 553 unless the agency rule is exempt from coverage of the APA, or the agency establishes "good cause" for not complying with the APA and waives notice and comment. When an agency waives notice and comment procedures required by the APA, however, there should be compelling reasons therefor. Courts have held that exceptions to APA procedures are to be "narrowly construed and only reluctantly countenanced." *New Jersey v. EPA*, 26 F.2d 1038, 1045 (D.C.Cir. 1980). The ninth circuit has stated that,

> "the good cause exception goes only as far as its name implies: It authorizes departures from the APA's requirements only when compliance would interfere with the agency's ability to carry out its mission. The agency must minimize conflict with the APA by

[2] *See* 63 Fed. Reg. 292 (January 5, 1998); 63 Fed. Reg. 10,730 and 63 Fed. Reg. 10,732 (March 4, 1998).
[3] *See* Letter from Jere W. Glover, Chief Counsel for Advocacy, to HCFA (April 15, 1998).

> complying with those APA requirements it is capable of complying with." *Riverbend Farms, Inc. v. Madigan*, 958 F.2d 1479, 1484 (9th Cir.), *cert. den.* 506 U.S. 999(1992).

As with the surety bond final rule, HCFA waived both the notice and comment requirement and the 30-day effective date requirement. In the case of the former, the agency based its good cause exception and waiver on the fact that data collection, within the 8-month statutory deadline set forth in the BBA, makes notice and comment impracticable.

With regard to impracticability arguments, as a general matter, "strict congressionally imposed deadlines, without more, by no means warrant invocation of the good cause exception." *Petry v. Block*, 737 F.2d 1193, 1203 (D.C.Cir. 1984). This same proposition is reiterated in a number of cases.[4] For instance, in *Western Oil & Gas v. United States E.P.A.*, 663 F.2d 803 (9th Cir. 1980), not only did the court state that the EPA could not rely solely on statutory deadlines to satisfy the good cause exception in enacting clean air standards, the court also stated that, "When substantive judgments are committed to the very broad discretion of an administrative agency, procedural safeguards that assure the public access to the decision-maker should be vigorously enforced." *Id.* at 813. Other jurisdictions have stated that there is no good cause exception where "an agency unwilling to provide notice or an opportunity to comment could simply wait until the eve of a statutory . . . deadline, then raise up the 'good cause' banner and promulgate rules without following APA procedures." *Council of Southern Mountains, Inc. v. Donovan*, 653 F.2d 573, 581 (D.C.Cir. 1981).

The basis for waiver of the prior notice requirement in this case is HCFA's need to gather "special" data from HCFA's fiscal intermediaries, and to generate an unduplicated census count to calculate the aggregate per-beneficiary limitations. However, the Office of Advocacy believes that if HCFA had simply issued a proposed rule outlining its data collection process and methodology for calculating the limits, then the vital public input process could have been preserved. The actual data could then be incorporated in a final rule. If the regulated industry knows the rules of the game, then the playing field is inherently more fair. HCFA had ample time and opportunity to follow proper notice and comment procedures; therefore, HCFA improperly relied on the on the impracticability argument to demonstrate that it had good cause to waive notice and comment.

Although HCFA invoked a post-effective date comment period in the final rule, this is not a valid substitute for the normal provisions of the APA. The third circuit stated that:

> "[i]f a period for comments, after issuance of a rule, could cure a violation of the APA's requirements, an agency could negate at will the Congressional decision that notice and an opportunity for comment must precede promulgation. Provisions of prior notice and comment allows effective participation in the rulemaking process while the decision maker is still receptive to information and argument. After the final rule is issued, the petitioner must come hat-in-hand and run the risk that the decision maker is likely to resist change." *Sharon Steel Corp. v. EPA*, 597 F.2d 377, 381 (3rd Cir. 1979).

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[4] *See generally Buschmann v. Schweiker*, 676 F.2d 352 (9th Cir. 1981) (good cause exception is essentially an emergency procedure).

Since HCFA improperly waived notice and comment and failed to otherwise provide effective participation in the rulemaking process, the agency must *also* comply with the Regulatory Flexibility Act.

II. Regulatory Flexibility Act Requirements

The RFA requires agencies to analyze the impact of proposed regulations on small entities and consider flexible regulatory alternatives that reduce the burden on small entities **even when a regulation is statutorily mandated.** Agencies may forgo the analysis if they certify (either in the proposed or final rule) that the rule will not have a significant economic impact on a substantial number of small entities. Agency compliance with certain provisions of the RFA, like the certification or final regulatory flexibility analysis, is judicially reviewable under section 611 of the RFA.

HCFA did not certify the IPS final rule. Instead, the agency made the following curious assertion regarding the impact of the final rule on small entities:

> "Since the aggregate per-beneficiary limitation will reduce payments by approximately nine percent [$1.06 billion in Federal FY 1998], we anticipate this rule will have a significant impact on a substantial number of small entities. We have examined the options for lessening the burden on small entities, however, the statute [BBA] does not allow for any exceptions to the aggregate per-beneficiary limitation based on the size of the entity. Therefore, we are unable to provide any regulatory relief for small entities." 63 Fed. Reg. at 15,734.

This statement reflects a clear misunderstanding by HCFA of the requirements of the RFA. Whether or not a statute provides for exceptions for small entities is completely irrelevant. The issue for HCFA should be whether there is latitude in interpreting the provisions of a statute to reduce the burden on small entities consistent with the stated regulatory objectives or applicable statutory requirements.[5] HCFA's so-called "regulatory flexibility analysis" is limited to a discussion of anticipated costs resulting from implementation of the final rule. No significant alternatives are discussed. More importantly, the public never had a meaningful opportunity to comment on the analysis as required by section 604(a)(2) of the RFA.[6] In spite of HCFA's

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[5] In addition, when a statute does not explicitly prohibit exemptions (as in the case of the BBA), an agency may still have the authority/discretion to consider exemptions when the agency's authorizing statute permits exemptions in crafting regulations.

[6] Recent case law supports the theory that there can be no valid final regulatory flexibility analysis without the benefit of public comment on an initial regulatory flexibility analysis (IRFA). In *Southern Offshore Fishing Association v. Daley,* 1998 WL 125775 (M.D.Fla. Feb. 24, 1998), the court rebuked the Secretary of Commerce for certifying the proposed rule establishing quotas for shark fisheries, then preparing a FRFA for the final rule in order to feign statutory compliance with the RFA,

> "Pursuant to section 603, an IRFA would have required [the National Marine Fisheries Service (NMFS)] to engage in a careful and meaningful study of the problem from the beginning. With notice of NMFS's position, the public could have engaged the agency in the sort of informed and detailed discussion that has characterized this litigation. Instead, NMFS chose an insular approach designed to block further investigation and public scrutiny. NMFS compounded this error by

claims to the contrary, the agency did have a number of choices in implementing the IPS regulation.

A. Poor Choices: Misinterpreting the Statute

Congress created many of the requirements outlined in the final rule. However, Congress' intent in creating the interim payment system was to discourage abuse—not to punish. Nevertheless, HCFA created additional unnecessary burdens on small entities when they decided to use certain data and methods of calculation in setting Medicare limits. In effect, the implementing regulation punishes law abiding and conscientious home health providers. The Office of Advocacy does not have the resources at this time to comment on all of the failings with regard to this particular regulation. However, there are some obvious and significant instances where HCFA had the opportunity to mitigate the burden on small entities while attempting to implement the statutory requirements of the BBA.

For instance, an adequate analysis of alternatives should have included other data sources that recognize regional differences in cost. The BBA of 1997 enacted additions to the cost limits establishing an agency-specific per-beneficiary annual limitation calculated based on 75% on 98% of the reasonable costs of a HHA's twelve month cost reporting period ending during fiscal year 1994 and based 25% on 98% of the standardized regional average of such costs for the agency's census division. "New" providers and those without a twelve-month cost reporting period ending in fiscal year 1994 (including those establishing new branches, etc.) would be subject to the per-beneficiary limitation equal to the median of these limits. The BBA does not define what "limits" are. HCFA, in interpreting the BBA, states that "new" providers will be subject to a per-beneficiary annual limitation calculated on the basis of the **national median** of the blended limits even though the terms "national data" and "national average" do not appear anywhere in the BBA.

By construing the BBA in this manner, HCFA accomplishes a negative and inequitable result among new providers. Certain benefits and/or losses will confer upon providers based solely upon their geographic location—regardless of the type of services generally needed by the patient population serviced by the agencies (case mix variation) or whether a particular provider had a history of running efficiently (versus one that had a history of over servicing). Moreover, HCFA's use of a national median for limits is antithetical to the desired movement toward a prospective payment system which rationally recognizes regional differences.

B. Poor Choices: Beyond Congressional Intent

Aside from awkward interpretations of the BBA requirements, HCFA has taken great liberties in designating additional categories for the definition of new providers not contained in the BBA. Section 1861(v)(1)(L)(vi)(I)of the BBA requires that the median limits apply only to new providers and those providers without a twelve month cost reporting period ending in fiscal year

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preparing a FRFA that constitutes an attempt to agreeably decorate a stubborn conclusion." *Id*. at 20.

1994. HCFA, however, includes acquired, merged or altered HHAs in the new provider category. In explaining the additions, HCFA's attempts to draw distinctions between corporate structure changes (which the BBA states will not result in new provider status), and operational structure changes. Not only do these additions/distinctions create a host of ambiguities when it comes to determining the definition of a new provider, it also casts a broad net and ensnares HHAs that would not otherwise have been deemed new providers under the BBA.

For instance, the Office of Advocacy was contacted by an HHA in Texas that will be reimbursed substantially less due to HCFA's expanded definition of a new provider.. Apparently this agency has been in business since about 1986, but changed their corporate and tax reporting structure in 1993. Because of this change, the agency only had eleven months of cost report data (--not the full twelve months) and therefore was considered a new provider. The agency is being regarded as though it had opened its doors in 1994. However, this agency has maintained the same Medicare provider number, has never interrupted service to its customers/patients, and has maintained an excellent reputation as a Medicare provider. The application of new provider status to this agency far exceeds what Congress intended and clearly stated. Moreover, there can be no legitimate public policy objective in paying new agencies less than old ones; and there certainly can be no legitimate public policy objective in punishing HHAs with a good record who have been in business since 1986.

C. Poor Choices: Inadequate Consideration of Impacts

The RFA requires, among other things, that an agency's final regulatory flexibility analysis (FRFA) must contain:

> "a description of the steps the agency has taken to minimize the significant economic impact on small entities consistent with the stated objectives of applicable statutes, including a statement of the factual, policy, and legal reasons for selecting the alternative adopted in the final rule and why each one of the other significant alternatives to the rule considered by the agency which affect the impact on small entities was rejected." 5 U.S.C. § 604(a)(5).

As already mentioned herein, no alternatives have been presented in the regulation which would minimize the significant economic impact on small entities. More disturbing, however, is the fact that the agency failed to include a factual statement of the reasons for selecting the alternatives adopted in the final rule.

For instance, HCFA failed to provide any type of factual basis for its use of a 65% offset in estimating the impact of the aggregate per beneficiary limitation on HHAs. HCFA states that the estimation of effects (of the per-beneficiary limit) includes an offset which

> "takes into account the behaviors that we believe HHAs will engage in order to reduce the adverse effects of [the BBA] on their allowable costs. We believe these behavioral offsets might include an increase in the number of low cost beneficiaries served, a general decrease in the number of visits provided, and earlier discharge of patients who are not eligible for Medicare home health benefits because they no longer need skilled services but have only chronic, custodial care needs. We believe that, on average, these behavioral offsets will

result in a 65-percent reduction in the effects these limits might otherwise have on an individual HHA." 63 Fed. Reg. at 15,735.

HCFA's arguments have the ring of plausibility, but greater examination reveals that HCFA has not actually stated any factual basis for the offset. The Office of Advocacy is unable to find any analysis supporting the amount of the offset. Without the offset, the actual projected savings to Medicare (or, reduction in payments to HHAs) would rise to $1.75 billion in federal fiscal year 1998 and $3.54 billion in 1999. This is a sharp contrast between the original savings estimates (which include the offset) of $1.06 billion and $2.14 billion. If HCFA has miscalculated the offset, the actual impact of the per-beneficiary limitation could rise exponentially into additional millions or billions.[7]

HCFA's estimates do not include beneficiary impacts. The RFA does not apply to individuals per se, but there is a human cost associated with the lack of services that will result from HHA closures and the impracticability of serving Medicare patients. The sickest and most acute patients who require longer term care will surely be the ones who lose service. HCFA's "behavioral offsets," after all, are based on the assumption that service will be reduced one way or another. If one of the possible effects of the IPS final rule is decreased service to beneficiaries—either due to HHAs going out of business, HHAs being unable to accept high cost patients, or HHAs dropping patients too early—the agency has abandoned its duty to Medicare beneficiaries and has gone far beyond Congress' goal of reducing fraud and abuse.

Who pays? The patients still exist and will not magically disappear. According to the National Association for Home Care (NAHC), the largest trade association representing home care agencies across the country, at least 57.9% of all HHAs will be forced to terminate their provider agreements with Medicare or to subsidize the Medicare program for services to patients. On average, NAHC says reimbursement will be 9.3% less than the cost of delivering care after all possible costs have been reduced.

Perhaps already overburdened state Medicaid agencies will pay for some of these patients after they have spent down all of their assets paying for health care services that should have been paid by Medicare. Perhaps hospitals will pay when sicker patients remain in hospitals longer—thereby costing Medicare more than if the patients had been released to an HHA sooner. Perhaps law abiding HHAs will pay and essentially subsidize Medicare in order to avoid forfeiting their businesses which may already be capitalized and collateralized by the total of their personal assets. HCFA should have included and analyzed all of these significant costs prior to implementing this regulation.

Conclusion

[7] The agency asserts that the cost-benefit analysis required under the Unfunded Mandates Reform Act does not apply to this rulemaking because there will be no annual expenditure by state, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. HCFA then states that there will be a $1.06 billion decrease in payments to HHAs in fiscal year 1998 and $2.14 billion in 1999. *See* 63 Fed. Reg. at 15,734. The Office of Advocacy is not certain how payments to HHAs can be significantly decreased without HHAs incurring direct costs in order to comply.

As with the surety bond regulation, HCFA has twisted Congress' intent and changed the instant rule into a vehicle for punishing legitimate home health agencies. The surety bond rule has evoked venomous reaction from HHAs, Congress, and the surety bond industry with regard to that rule's impact. This final rule has already served as the basis of several lawsuits around the country because of the agency's failure to assess the impact adequately and present less burdensome alternatives. Sequential billing is also being proposed and will cause HHAs to carry debt for longer periods. Increased audits have already been occurring nationwide. All of these regulations and practices will devastate the home health industry. It is unimaginable that HCFA could be unaware of the impact of this series of regulations that attempt to implement the provisions of the BBA.

Therefore, the Office of Advocacy petitions HCFA to amend its final rule to comport with the requirements of the BBA, or in the alternative, to rescind the final rule until such time as proper notice and comment procedures and a proper analysis can be completed.

Thank you for your attention to this matter. Please contact our office if we may assist you in your efforts to comply with the RFA on this or any other rule effecting small entities, 202-205-6533.

Sincerely,

Jere W. Glover
Chief Counsel for Advocacy

Shawne Carter McGibbon
Asst. Chief Counsel for Advocacy

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